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F 000	INITIAL COMMENTS The following citations represent the findings of complaint investigations for complaints #72182, #70964, #70048, and #69656. A revised 2567 was electronically sent to the facility on 2/6/14.	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update	F 157		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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the address and phone number of the resident's legal representative or interested family member.

This REQUIREMENT is not met as evidenced by:
The facility census totaled 98 residents with 8 included in the sample. Based on interview and record review, the facility failed to notify the physician when a resident developed a pressure ulcer and failed to notify an interested family member when a resident experienced repeated skin tears for 2 of 8 sampled residents. (#2 and #4)

Findings included:

- Review of the nurse's notes for resident #2 revealed that over the months of July, September, October and November 2013, the staff documented the resident experienced new skin tears or re-opened old skin tears a total of 10 times. The documentation lacked evidence staff notified the family of the repeated issues with skin.

According to the nurse's notes, on 8/13/13 staff discovered a large bruise on the top of the resident's foot. Staff failed to contact the family and physician regarding the bruise.

Further review of the nurse's notes revealed that on 10/1/13 staff received an order to start the resident on an antibiotic for a skin tear that became infected. On 10/8/13, the physician discontinued 5 of the resident's oral medications and started the resident on narcotic pain medication and an antianxiety medication. The documentation lacked evidence the staff notified

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the family of these changes in the resident's medication regimen.

On 1/28/14 at 4:50 p.m., Administrative nurse B stated staff were expected to call the families and report whenever there was an injury, a fall, or a medication change with the residents.

Review of the facility's undated Notification Parameters policy directed staff to notify the resident's interested family member of any significant change in the resident's status, unless the resident had specified otherwise. The policy also provided guidance to staff to document all attempts to contact the primary care physician and the family/legal represetative.

The facility failed to notify an interested family member whenever a resident experienced multiple skin tears, obtained a bruise of unknown source, and had medication changes.

- Review of a wound assessment for resident #4 revealed staff identified the resident had a reddened area on his/her left buttock on 1/3/14. Review of the next wound assessment, dated 1/22/14, staff documented they had identified five open areas, four Stage II (open area that presents as a shallow crater) and one Stage III (an open area that involves the underlying dermis). The record lacked evidence the staff told the physician or the family regarding the development of the open areas.

On 1/31/14 at 9:50 a.m., a nurse from the office of the resident's physician stated he/she had looked and could not find anything that indicated the staff had notified the physician, either by phone or by fax, that the resident had developed

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F 157	Continued From page 3 several open areas. Review of the facility's undated Notification Parameters policy directed staff to notify the resident's interested family member of any significant change in the resident's status, unless the resident had specified otherwise. The policy also provided guidance to staff to document all attempts to contact the primary care physician and the family/legal represetative. Review of the facility's undated Physician Notification Parameters policy revealed the guidance to staff to notify the physician immediately of the development of any Stage III or IV that were recieving no treatment or had new complications. For the development of new Stage II and any stage when the current treatment was not effective, the guidance directed staff to notify the physician, but it was a non-immediate case. The policy identified non-immediate notification was notifying the physician of the event during normal office hours, and generally no later than the next regular office day. If a non-immediate event occured on a weekend or holiday, then the licensed nurse must determine if the notification could wait until the next office day or whether the on-call physician should be notified during daytime hours. The facility failed to notify the family and the physician regarding the development of multiple pressure ulcers for a resident.	F 157		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have	F 225		

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been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.

The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).

The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.

The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

This REQUIREMENT is not met as evidenced by:
The facility census totaled 98 residents with 8 included in the sample. Based on interview and

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record review, the facility failed to investigate and report a large bruise to the top of the foot for 1 of 8 residents. (#2)

Findings included:

- Review of the physician orders signed on 10/15/13 identified resident #2 had diagnoses of Alzheimer 's disease (progressive mental disorder characterized by failing memory, confusion), CAD (Coronary Artery Disease--abnormal condition that may affect the flow of oxygen to the heart), DM II (Diabetes Mellitus, type II--when the body can't use glucose, there's not enough insulin made or the body can't respond to the insulin), and chronic renal failure (inability of the kidneys to excrete wastes, concentrate urine and conserve electrolytes).

Review of the annual MDS (Minimum Data Set-a required assessment) dated 4/9/13 identified the resident with short and long-term memory problems, modified independence in making decisions regarding tasks of daily life, had daily inattention and disorganized thinking. The assessment also identified the resident required extensive assistance from one staff with bed mobility, transfers, and had no skin tears.

Review of the quarterly MDS dated 10/1/13 identified the resident with a BIMS (Brief Interview for Mental Status) score of 3/15 (indicating severely impaired cognition), required extensive assistance from two staff with bed mobility, transfers, had skin tears, and staff applied nonsurgical dressings.

Review of the Pressure Ulcer CAA (Care Area Assessment-a further assessment), dated

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4/16/13, identified the resident required assistance from staff with positioning and the resident did not walk.

Review of the care plan dated 10/8/13, identified the resident required bed mobility with 1-2 staff assist, and used a mechanical lift with 1-2 staff assist for transfers.

Review of the nurse's notes revealed on 8/13/13 at 9:50 p.m., staff documented the discovery of a bruise on top of the resident's left foot that measured 7 cm (centimeters) x 9 cm in size. The documentation lacked evidence staff knew what caused the bruise, or that an investigation occurred, but that staff planned to monitor the foot.

Review of a nurse's note dated 9/5/13 and timed 9:30 p.m. revealed staff conducted a skin assessment on the resident and determined the bruise to the top of the left foot "continues" and the staff planned to continue to monitor the bruise. The bruise had not resolved over 3 weeks later.

On 1/23/14 at 9:10 a.m., Administrative staff C stated there had been a change in the Director of Nurse position since 9/2013, and the facility was unable to locate any investigations the previous DON had conducted. Staff C stated the facility did not have evidence an investigation occurred on this bruise of unknown source. Staff C also stated that it was the facility's policy to investigate all injuries of unknown origin and call them into the State. Staff C stated he/she had no record this injury was reported.

The facility failed to investigate a bruise of

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F 225	Continued From page 7 unknown source and report the injury to the State.	F 225		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: The facility census totaled 98 residents with 8 included in the sample. Based on observation, interview, and record review, the facility failed to develop and implement a care plan that addressed fragile skin, bruising, and use of a mechanical lift for 3 of the 8 sampled residents. (#2, #3, and #4) Findings included:	F 279		

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- Review of the physician review of orders signed on 10/15/13 identified resident #2 had diagnoses of Alzheimer 's disease (progressive mental disorder characterized by failing memory, confusion), and DM II (Diabetes Mellitus, type II--when the body can't use glucose, there's not enough insulin made or the body can't respond to the insulin).

Review of the annual MDS (Minimum Data Set-a required assessment) dated 4/9/13 identified the resident with short and long-term memory problems, modified independence in making decisions regarding tasks of daily life, had daily inattention and disorganized thinking. The assessment also identified the resident required extensive assistance from one staff with bed mobility, transfers, and had no skin tears.

Review of the quarterly MDS dated 10/1/13 identified the resident with a BIMS (Brief Interview for Mental Status) score of 3/15 (indicating severely impaired cognition), required extensive assistance from two staff with bed mobility, transfers, had skin tears, and staff applied nonsurgical dressings.

Review of the care plan for impaired skin integrity, dated 10/8/13 directed staff to assist with repositioning at least every 2 hours, to conduct weekly skin assessments by a licensed nurse, monitor skin during dressing, peri-care and bathing for signs of potential skin breakdown (such as redness, discoloration or open areas) and notify charge nurse of abnormal findings - particularly to feet and hands. It also directed staff to apply moisturizing skin lotion to skin after each bath and PRN (as needed). The care plan

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lacked identification of the resident's fragile skin, or interventions for staff to protect the resident's skin against skin tears.

Review of the nurse's notes revealed staff documented the resident received skin tears or re-opened old skin tears 10 different times over a 4 month period--July, September, October and November 2013.

On 1/28/14 at 4:50 p.m., Administrative nurse B confirmed staff should have developed a care plan that addressed the resident's fragile skin.

The facility failed to develop and implement a care plan that addressed this resident's fragile skin in an effort to prevent skin tears.

- Review of physician's orders, dated 1/17/14, identified resident #3 had the diagnosis of anoxic brain damage (injury to the brain due to a lack of oxygen), and had a surgical hip repair.

Review of the significant change in status MDS (Minimum Data Set-a required assessment) dated 1/3/14, identified the resident with a BIMS (Brief Interview for Mental Status) score of 7/15 (indicating severely impaired cognition), had one Stage 1 (intact) pressure ulcer and used a pressure relieving device while in the bed.

Review of the Pressure Ulcer CAA dated 1/3/14 revealed the resident was readmitted to the facility from the hospital with redness to the resident's bottom. Staff applied aloe as needed per standing order. The resident also returned from the hospital with multiple bruises to both of his/her arms from laboratory tests as well as bruising to abdominal area from Lovenox (a blood

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thinner) injections.

Review of the care plan, dated 1/14/14 identified the resident required 2 staff extensive assistance with bed mobility, transfers, ambulation, mobility, dressing and toilet use. The impaired skin integrity care plan directed staff to monitor that the resident was repositioned at least every 2 hours. Assist with repositiong as needed, weekly skin assessment by licensed nurse and monitor skin during dressing, pericare and bathing for signs of potential skin breakdown (such as redness, discoloration or open areas). Notify charge nurse of abnormal findings, provide good peri-care with each incontinent episode, and apply moisturizing skin lotion to skin after each bath and PRN (as needed). The care plan lacked the identification of the multiple bruising on the resident.

Review of the nurse's notes revealed the staff documented the monitoring of the deep purple bruising on the resident's abdomen and both arms daily after the resident returned from a hospitalization, but the monitoring lacked measurements or descriptions to ensure the bruises resolved as expected.

On 1/24/14 at 3:00 p.m., Administrative staff C stated he/she knew there were concerns with the resident's bruising on the abdomen and arms.

On 1/28/14 at 4:50 p.m., Administrative Nurse B stated he/she understood the concern about not measuring the bruises when staff assessed them. Just mentioning that the resident continued to have bruising in the same area each day wasn't a comprehensive assessment.

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The facility failed to care plan the presence of extensive dark purple bruising for a resident.

- Review of resident #4's physician's review of orders, dated 11/18/13, identified the resident with the diagnoses of edema, PVD (Peripheral Vascular Disease-any abnormal condition affecting the blood vessels), and renal insufficiency (insufficient excretion of wastes by the kidneys).

Review of the annual MDS (Minimum Data Set-a required assessment) dated 5/7/13, identified the resident with a BIMS (Brief Interview for Mental Status) score of 7/15 (indicating severely impaired cognition), required supervision with oversite with bed mobility, transfers, at risk for the development of pressure ulcers, without pressure ulcers, and used a pressure relieving device in the bed.

Review of the quarterly MDS dated 10/22/13 identified the resident with a BIMS score of 8/15 (indicating moderately impaired cognition), required limited assistance from one staff with transfers, supervision from one staff with bed mobility, walking in the room, at risk for the development of pressure ulcers, had one Stage 1 pressure ulcer (intact, not open), and used a pressure reducing device for the chair and the bed.

Review of the Pressure Ulcer CAA (Care Area Assessment-a further assessment) dated 5/4/13 revealed the resident had a history of arterial ulcers from PVD and a bilateral femoral stent placement (placing a tiny, expandable metal coil-stent-into the major arteries in both legs). The CAA identified staff monitored the resident's

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skin on a regular weekly basis per the facility's nursing standard. The CAA identified staff applied a moisture barrier cream to the resident's buttocks as a preventative measure, used a pressure relieving mattress but refused a chair cushion. The assessment identified the resident at risk for impaired skin integrity due to the resident's incontinence, edema, and decreasing mobility.

Review of the care plan, dated 10/29/13, directed staff to apply moisturizing lotion after each bath, monitor floor of the resident's room for wet pull ups, assist the resident with toileting as he/she allowed as the resident frequently refused help with toileting and personal cares and became agitated easily, encourage/remind the resident to keep his/her feet elevated when seated. Encourage the use of wraps every day. Weekly skin assessment by licensed nurse and calmoseptine ointment to buttocks every shift and PRN until resolved. The care plan lacked evidence the resident had multiple open areas, or the current treatment to help the areas resolve.

Review of the January TAR (Treatment Administration Record) revealed staff obtained an order to use DuoDerm (an occlusive dressing) on the resident's buttocks on 1/10/14. The record lacked a corresponding skin assessment with this order.

Review of a wound assessment, dated 1/22/14, identified the resident had 5 open areas on the left buttock. The staff identified four of the open areas as Stage II (partial thickness skin loss involving epidermis, dermis, or both. The ulcer is superficial and presents clinically as an abrasion, blister or shallow crater) and one of the open

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F 279	Continued From page 13 areas as a Stage III (full thickness skin loss involving damage to, subcutaneous tissue that may extend down to, but not through, underlying fascia. The ulcer presents clinically as a deep crater with or without undermining of adjacent tissue). The staff assessment identified the Stage II areas measured 0.5 cm (centimeters), 0.6 cm, 0.6 cm and 1.1 cm in size. The staff documented the one Stage III as 0.8 cm in size and identified the treatment as Duoderm. On 1/23/14 at 1:22 p.m., observation of the resident's buttocks revealed the resident's coccyx was a bright red and there was a duoderm on the left buttock. The skin around the duoderm was also bright red. The duoderm was intact and dated 1/22/14. On 1/23/14 at 1:25 p.m., licensed nurse H stated he/she looked at the resident's buttocks every day to make sure the duoderm remained in place. Nurse H stated the facility had just placed the cushion in the recliner "yesterday" to help offload the residents' buttocks since he/she was "sitting so much". The care plan lacked the plan to place a cushion in the resident's recliner. The facility failed to develop and implement a plan to treat multiple open areas for a resident.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.	F 280		

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A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.

This REQUIREMENT is not met as evidenced by:
The facility census totaled 98 residents with 8 included in the sample. Based on observation, interview and record review, the facility failed to revise the care plans of 2 sampled residents (#5 and #8) in regards to the development of pressure sores and the need to increase staff supervision to decrease falls.

Findings included:

- Review of resident #5's diagnoses, located on the admission and discharge summary sheet dated 3/14/13, identified the resident with the diagnoses of DMII (Diabetes Mellitus--when the body can't use glucose, there's not enough insulin made or the body can't respond to the insulin), and delusional disorder (an untrue persistent belief or perception held by a person although evidence shows it is untrue).

Review of the significant change in status MDS

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(Minimum Data Set-a required assessment) dated 6/27/13 identified the resident with a BIMS (Brief Interview for Mental Status) score of 5/15 (indicating severely impaired cognition), required extensive assistance from 2 staff with bed mobility, transfers, toilet use, personal hygiene, at risk for the development of pressure ulcers, did not have pressure ulcers, used pressure reducing devices for the chair, bed, and was on a turning/repositioning program.

Review of the quarterly MDS dated 12/24/13 identified the resident with short and long-term memory problems, with inattention and disorganized thinking that did not fluctuate, required extensive assistance from 2 staff with bed mobility, transfers, toilet use, personal hygiene, at risk for the development of pressure ulcers, had no pressure ulcers, used a pressure reducing device for the chair/bed, and staff utilized a turning/repositioning program for the resident.

Review of the Pressure Ulcer CAA (Care Area Assessment-a further assessment), dated 6/24/13 revealed the resident had a decrease in mobility, and had lost a significant amount of weight which placed the resident at risk for impaired skin. Other contributing factors included the resident's diagnosis of diabetes with neuropathy (disease or dysfunction of one or more peripheral nerves, typically causing numbness or weakness), bowel and bladder incontinence, impaired cognition and resistance to care.

Review of the care plan, dated 12/31/13, revealed the resident was at risk for impaired skin integrity related to diabetes. It directed staff to apply skin

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protectant to the resident's buttocks as needed, monitor an area on the resident's inner thigh (looks like birthmark) that the resident had said that he/she has had for years. If staff noted changes, (such as irregular borders, color or size changes) notify the physician. Turn and reposition the resident at least every 2 hours, the facility's licensed nurses were to conduct weekly skin assessment, monitor skin during care for signs of potential skin breakdown, and apply moisturizing skin lotion to skin after each bath and PRN (as needed). The care plan lacked evidence of the resident's current pressure ulcer, or the expected treatment to help it heal.

Review of the January 2014 TAR (Treatment Administration Record) revealed staff obtained an order to use a moisture barrier cream starting on 1/13/14.

On 1/24/14 at 8:38 a.m., observation of the resident's buttocks revealed two small, undated DuoDerm dressings (an occlusive dressing) on each ischial tuberosity (when a person is in a seated position, his or her weight typically rests on a section of bone called the ischial tuberosity).

On 1/24/14 at 9:55 a.m., licensed nurse A stated the resident developed an open area and he/she had measured the area on 1/21/14 and it measured 8 mm (millimeters) x 5 mm at that time and was looking good. However, licensed nurse P worked yesterday (1/22/14) and must have thought it looked worse, because nurse P put a duoderm on both buttocks, one that had an open area and the other buttock had another area that nurse P thought looked like it might be starting to open. Nurse A stated the resident sat on a foam cushion, but that was a cushion the resident "had

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always" had. Nurse A stated the resident received hospice services and hospice had ordered a different type of cushion for the resident, a gel cushion. None of that information was included in the care plan.

The facility failed to develop and implement a plan to treat a pressure sore for a resident.

- Review of the admission and discharge summary sheet, dated 12/20/13, identified resident #8 had the diagnoses of depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness), postural hypotension (low blood pressure occurring in some people when they stand up), and osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain.

Review of the significant change in status MDS (Minimum Data Set-a required assessment) dated 12/29/13 identified resident #8 with short and long-term memory problems, with moderately impaired cognition, had consistent inattention, disorganized thinking, inconsistent altered level of consciousness, required extensive assistance from two staff with bed mobility, transfers, walking in the room, toilet use, personal hygiene, and had one non-injury fall since the last assessment.

Review of the Fall CAA (Care Area Assessment), completed with the MDS on 12/29/13, identified the resident at risk for falls, had a recent history of falls, and also fell since admission. Particularly early in the assessment period, the resident was restless, tried to climb out of bed or the wheelchair, wandered while in the wheelchair and was resistive to care. It also identified the

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resident required 1-2 assist of staff for ADLs (Activities of Daily Living), had confusion, difficulty communicating, occasional incontinence, orthostatic hypotension and received psychotropic medication.

Review of the care plan, dated 1/7/14, identified the resident required 2 staff assist with bed mobility, transfers and ambulation. It also identified the resident used a walker and his/her gait was slow and directed staff to not to rush the resident. The fall care plan directed staff to cue the resident to change positions slowly to avoid increased dizziness. Do not encourage the resident to ambulate after standing until he/she felt the dizziness had resolved, and to use standard fall precautions, which included the following: keep call light within reach, instruct and encourage the use of call system. Respond promptly to call light. Keep as many items as possible within the resident's reach so that reaching is not necessary. Bed in low position, casters locked. Wheelchair locked when not in motion. Keep room clean, pathways, clear. Ensure clear access from bed to bathroom. Monitor for safety hazards (such as water on floor, papers or trash on floor). Shoes, footwear on when the resident was up. Non-skid socks on when in bed. Monitor for condition/fit of shoes. Have repaired/replaced as needed. The care plan failed to address the need for increased supervision.

Review of the fall investigations into 5 falls the resident experienced from 10/2013 through 1/2014 revealed in all investigations, staff recommended the resident needed more supervision.

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F 280	Continued From page 19 On 1/24/14 at 8:15 a.m., observation revealed direct care staff K pushed the resident out of the dining room to a table in the lobby. Staff K left the resident at the table and returned to the dining room and assisted another resident to finish eating. Observation revealed the back of the resident's wheelchair had a personal body alarm attached to it and there were no nursing staff in the lobby to observe the resident. On 1/28/14 at 4:50 p.m., Adminsitrative nurse B agreed the staff did not place the intervention of closer supervision in the care plan and the increased supervision was not completed. The facility failed to develop a care plan that directed staff to provide more supervision due to the resident's high risk of falls.	F 280		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: The facility census totaled 98 residents with 8 included in the sample. Based on interview and closed record review, the facility failed to assess causal factors for the repeated development of skin tears to develop, plan and implement effective interventions to prevent further skin	F 309		

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tears for 1 of 4 sampled residents. (#2)

Findings included:

- Review of the physician review of orders signed on 10/15/13 identified resident #2 had diagnoses of Alzheimer 's disease (progressive mental disorder characterized by failing memory, confusion), CAD (Coronary Artery Disease--abnormal condition that may affect the flow of oxygen to the heart), DM II (Diabetes Mellitus, type II--when the body can't use glucose, there's not enough insulin made or the body can't respond to the insulin), and chronic renal failure (inability of the kidneys to excrete wastes, concentrate urine and conserve electrolytes).

Review of the annual MDS (Minimum Data Set-a required assessment) dated 4/9/13 identified the resident with short and long-term memory problems, modified independence in making decisions regarding tasks of daily life, had daily inattention and disorganized thinking. The assessment also identified the resident required extensive assistance from one staff with bed mobility, transfers, and had no skin tears.

Review of the quarterly MDS dated 10/1/13 identified the resident with a BIMS (Brief Interview for Mental Status) score of 3/15 (indicating severely impaired cognition), required extensive assistance from two staff with bed mobility, transfers, had skin tears, and staff applied nonsurgical dressings.

Review of the Pressure Ulcer CAA (Care Area Assessment-a further assessment), dated 4/16/13, identified the resident required assistance from staff with positioning and the

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resident did not walk.

Review of the care plan for impaired skin integrity, dated 10/8/13 directed staff to assist with repositioning at least every 2 hours, to conduct weekly skin assessments by a licensed nurse, monitor skin during dressing, peri-care and bathing for signs of potential skin breakdown (such as redness, discoloration or open areas) and notify charge nurse of abnormal findings - particularly to feet and hands. It also directed staff to apply moisturizing skin lotion to skin after each bath and PRN (as needed). The care plan lacked identification of the resident's fragile skin, or interventions for staff to protect the resident's skin against skin tears.

Review of the nurse's notes revealed staff documented the following:

On 07/08/13 at 10:00 a.m., skin tear while being transferred to sit/stand lift.

On 07/08/13 at 4:00 p.m., Skin tear to right elbow cleansed, approximated and steri stripped (type of bandage). Covered with OpSite (an occlusive bandage).

On 9/9/13 at 12:09 a.m., new order for treatment to left upper arm skin tear: Apply steri strips or occlusive dressing, Change PRN until resolved. Upon transfer from toilet, bruised/ecchymosis area opened and skin tear noted. Per protocol, staff cleansed the area with Shur cleans (type of cleaning lotion) and applied steri strips.

On 9/28/13 at 9:30 p.m., Tegaderm (type of dressing) on resident's right lateral (side) forearm removed. 4 cm (centimeters) long x 1 cm wide,

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reddened partial thickness wound with some maceration surrounding. Yellow/green exudate (drainage). Cleaned, applied TAO (triple antibiotic ointment) and Covaderm (brand name of an occlusive dressing). Fax to doctor for treatment orders.

On 10/4/13 at 1:19 a.m., new orders 1) PRN cleanse right forearm with normal saline. Apply TAO, cover with occlusive dressing, check daily 2) check temperature every shift.

On 10/11/13 at 7:40 a.m., during toileting prior to breakfast elder received an abrasion/skin tear to the left hand.

On 10/17/13 at 7:30 p.m., right elbow. Resident opened an old skin tear to right elbow. Site cleansed; approximated, steri strip with OpSite cover.

On 11/9/13 at 2:00 p.m., Aide noticed blood on patients TED (Thrombo-Embolic-Deterrent) - specialized compression stockings designed to help manage excess fluid in the feet/legs) hose. Small skin tear.

On 11/13/13 at 7:00 a.m., patient has skin tear when TED hose applied-weeping occurs-TED Hose removed.

On 11/13/13 at 3:30 p.m., After shower, steri strips applied to right lower extremity, skin tear and Covaderm 4 x 4 (size of dressing) to cover. Bleeding slightly. Also scratch noticed on left cheek.

The record lacked documentation staff attempted to determine causal factors of the skin tears, and

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failed to develop, plan, and implement effective interventions to prevent additional occurrences of skin tears.

On 1/23/14 at 1:04 p.m., direct care staff F stated he/she remembered the resident. Staff F stated the resident's dementia sort of "took over" and the resident just declined. Staff F remembered the resident had skin tears-he/she had "really fragile skin; you had to be real careful" with him/her.

On 1/23/14 at 3:05 p.m., direct care staff I stated the resident did have skin tears. Staff I said staff did not use anything special to prevent skin tears-the staff were just very careful with the resident.

On 1/24/14 at 1:30 p.m., licensed nurse A stated he/she remembered the resident had very fragile skin and it would tear when staff barely touched it. Everyone knew they just needed to be careful when they handled the resident.

On 1/29/14 at 9:30 a.m., administrative nurse B agreed staff should have determined what caused the skin tears to try and see what they could do so the resident did not get so many.

Review of the facility's undated policy on Wound Care Protocol directed staff to complete an Incident report for any skin tear, lacerations, or bruises.

The facility's undated policy on Skin Assessment and Care directed staff that all skin tears, bruises, and all other skin conditions will be assessed for cause, with the treatment to follow either the standing orders of the physician or the specific

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F 309	Continued From page 24 orders of the physician. It also directed staff that residents with fragile skin prone to skin tears was to be protected with covering such as long sleeves and/or stockinette covering on arms, and protective hosiery and/or stockinette coverings on the lower extremities. The facility failed to assess multiple skin tears for causal factors to ensure staff developed, planned, and implemented effective interventions to prevent additional occurrences of skin tears.	F 309		
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: The facility census totaled 98 residents with 8 included in the sample. The sample included the review of 4 residents at risk for the development of pressure ulcers. Based on observation, interview, and record review, the facility failed to consistently provide assessments of pressure ulcers, failed to change the treatment for a resident with a stage I pressure ulcer, failed to assess and address a resident's increased need for repositioning assistance, and failed to reposition a dependent resident as frequently as	F 314		

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planned for 4 of the 4 residents reviewed. (#2, #4, #5 and #6) Resident #4 developed four Stage 2 pressure ulcers and one Stage 3 pressure ulcer.

Findings included:

- Review of resident #4's physician's review of orders, dated 11/18/13, identified the resident with the diagnoses of edema, PVD (Peripheral Vascular Disease-any abnormal condition affecting the blood vessels), and renal insufficiency (insufficient excretion of wastes by the kidneys).

Review of the annual MDS (Minimum Data Set-a required assessment) dated 5/7/13, identified the resident with a BIMS (Brief Interview for Mental Status) score of 7/15 (indicating severely impaired cognition), required supervision with oversight in bed mobility and transfers, was at risk for the development of pressure ulcers, without pressure ulcers, and used a pressure relieving device in the bed.

Review of the quarterly MDS dated 10/22/13 identified the resident with a BIMS score of 8/15 (indicating moderately impaired cognition), required limited assistance from one staff with transfers, supervision from one staff with bed mobility and walking in the room, was at risk for the development of pressure ulcers, had one Stage 1 pressure ulcer (intact, not open), and used a pressure reducing device for the chair and the bed.

Review of the Pressure Ulcer CAA (Care Area Assessment-a further assessment) dated 5/4/13 revealed the resident had a history of arterial

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ulcers from PVD and a bilateral (both) femoral stent (a tiny, expandable metal coil place in the large leg arteries to help keep the vessels open and the blood flowing) placement. The CAA identified staff monitored the resident's skin on a regular weekly basis per the facility's nursing standard. The CAA identified staff applied a moisture barrier cream to the resident's buttocks as a preventative measure, used a pressure relieving mattress but the resident refused a chair cushion. The assessment identified the resident at risk for impaired skin integrity due to the resident's incontinence, edema, and decreasing mobility.

Review of the care plan, dated 10/29/13, directed staff to apply moisturizing lotion after each bath, monitor floor of the resident's room for wet pull ups, assist the resident with toileting as he/she allowed as the resident frequently refused help with toileting and personal cares and became agitated easily, and encourage/remind the resident to keep his/her feet elevated when seated. Encourage the use of wraps every day. Weekly skin assessment by licensed nurse and calmoseptine ointment to buttocks every shift and PRN until resolved.

Review of the physician ' s review of orders, dated 11/18/13, identified the staff could use skin care - implement facility wound protocol for treatment of skin tears, pressure ulcers, and monitoring of bruises.

Review of a wound assessment sheet revealed staff documented on 1/3/14 that the resident had a Stage I (intact, but reddened) area on the left buttock that measured 0.8 cm (centimeters) x 0.5 cm in size. The assessment lacked

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documentation that staff initiated a treatment. The medical record lacked evidence staff notified the physician of the impairment in the resident's skin.

Review of the January 2014 TAR (Treatment Administration Record) revealed on 1/10/14, staff initiated a treatment order for staff to apply DuoDerm (an occlusive dressing) to the resident's buttocks and change the dressing every 5-7 days. Further review of the TAR revealed guidance to staff to conduct a skin assessment weekly by a licensed nurse. According to the TAR, a licensed nurse had conducted a skin assessment once during the month, on 1/27/14.

The next wound assessment, dated 1/22/14 or 11 days after the initiation of the DuoDerm treatment, identified the resident now had 5 open areas on the left buttock. The staff identified four of the open areas as Stage 2 (Partial thickness skin loss involving epidermis, dermis, or both. The ulcer is superficial and presents clinically as an abrasion, blister or shallow crater) and one of the open areas as a Stage 3 (Full thickness skin loss involving damage to, or necrosis [dead/dying tissue] of, subcutaneous tissue that may extend down to, but not through, underlying fascia. The ulcer presents clinically as a deep crater with or without undermining of adjacent tissue). The staff assessment identified the Stage II areas measured 0.5 cm, 0.6 cm, 0.6 cm and 1.1 cm in size. The staff documented the one Stage III as 0.8 cm in size and identified the treatment as Duoderm (an occlusive dressing). The record lacked evidence staff notified the physician of the development of multiple pressure ulcers.

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Review of the resident's laboratory testing revealed on 1/12/14 the resident had a stool specimen that tested positive for C. diff (Clostridium Difficile-"C. diff", is a species of Gram-positive spore-forming bacterium that is best known for causing antibiotic-associated diarrhea).

On 1/15/14, the nurse on the 6-2 shift and the 10-6 shift completed a resident summary that identified the resident used a pressure reducing device while in the chair, but was not on a turning/repositioning program.

On 1/18/14, the nurse on the 2-10 shift also completed a resident summary that identified the resident used a pressure reducing device while in the chair and not on a turning/repositioning program.

On 1/23/14 at 1:22 p.m., direct care staff F and G and licensed nurse H put on gowns, gloves and entered the resident's room. Observation revealed the resident sat in the recliner without it being reclined. Staff F and G attempted to use a walker and assist the resident to stand, but he/she refused, so staff F removed the gown and gloves, left the room and returned with a sit to stand mechanical lift. Nurse H stated that since the resident had been diagnosed with C. diff, he/she had become weaker and did not want to move as much, so staff were having to have help with the lift. Staff F and G placed the resident in the mechanical lift, and raised the resident into a standing position. Staff G removed the resident's brief, while nurse H looked at the resident's buttocks. Observation of the resident's buttocks revealed the resident's coccyx was a bright red and there was a duoderm on the left buttock.

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The skin around the duoderm was also bright red. The duoderm was intact and dated 1/22/14. Nurse H stated he/she looked at the resident's buttocks every day to make sure the duoderm remained in place. Observation of the recliner revealed a foam cushion was in the seat of the recliner. Nurse H stated the facility had just placed the cushion in the recliner "yesterday" to help offload the residents' buttocks since he/she was "sitting so much". Staff F and G then asked the resident if he/she needed to use the restroom (the resident stated no), placed a clean brief on the resident, pulled up his/her pants and sat the resident back in the recliner and left the resident's room at 1:38 p.m.

Observations revealed the resident remained in the recliner without a position change through observations at 1:57 p.m., 2:10 p.m., 2:23 p.m., 2:38 p.m., 2:45 p.m., 2:57 p.m., 3:10 p.m., 3:23 p.m., 3:35 p.m., 3:41 p.m., and 3:50 p.m.

On 1/23/14 at 4:04 p.m., after no position change for 2 hours and 26 minutes, direct care staff I and M put on gowns, hair coverings, masks, foot coverings and gloves and entered the room. The staff assisted the resident to stand, using the mechanical lift. The duoderm remained in place, and observation of the resident's buttocks revealed they were reddened. The staff changed the resident's incontinent brief, then assisted the resident to sit in the recliner again. Staff I stated at that time that the resident had become weaker in the previous weeks because he/she had gotten sick and he/she no longer wanted to get up out of the recliner, which was why staff I thought the resident had developed the areas. Staff I said the resident "used to be" independent, but now staff had to check on him/her every 2 hours and the

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staff needed to use a lift to help the resident.

On 1/23/14 at 1:25 p.m., direct care staff F stated that the resident no longer liked to stand, but they had to check the resident's brief and change it because the resident had "sores starting on [his/her] back side."

On 1/23/14 at 2:23 p.m., direct care staff I stated that the resident did not usually take snacks, so he/she was glad the resident took them today, since he/she needed them to help his/her sores heal.

On 1/23/14 at 1:22 p.m., licensed nurse H stated the facility had put a cushion in the seat of the resident's recliner yesterday to try and offload the resident's buttocks, since he/she liked to sit in the chair so much. The resident's family member had talked to the resident and convinced him/her since he/she had pressure sores on his/her bottom to lay down in bed during the night.

On 1/28/14 at 4:50 p.m., Administrative nurse B stated the resident had "chronic issues" with open areas that developed, then closed, then reopened. Nurse B stated he/she thought there should have been another wound assessment between the two that he/she provided, but nurse B could not find another assessment. Nurse B agreed that the wounds had gotten worse, but he/she believed it was because the resident had C. diff and had issues with diarrhea. He/she said the resident had been independent in his/her room prior to getting sick, so staff should have recognized that the resident was weaker during that time and needed more help. Nurse B said the staff probably was expecting the resident to return to become more independent, once his/her

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illness resolved.

On 1/31/14 at 9:50 a.m., a nurse from Physician T's office stated the physician lacked knowledge regarding the resident's multiple pressure ulcers, and the nurse had looked thoroughly into the resident's chart at the office, and it lacked any notification from the facility staff regarding the resident's development of pressure ulcers in January 2014.

Review of the facility's undated Pressure Ulcer Prevention Protocol, identified staff were to conduct weekly skin assessments for pressure ulcers using an EZ graph and were to include staging, size, depth, drainage, tunneling, odor, degree of healing and an assessment of pain associated with the pressure areas. The protocol also identified any pressure ulcer which did not demonstrate healing would have interventions changed in a timely manner.

The facility failed to change the treatment once a resident developed a Stage I pressure ulcer, failed to conduct weekly skin assessments and failed to develop a plan to address the resident's increased dependence on staff for repositioning needs. The resident developed four Stage 2 pressure ulcers and one Stage 3 pressure ulcer.

- Review of resident #6's physician's review of orders, dated 12/17/13, identified the resident with the diagnoses of depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness), osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain), CVA (Cerebrovascular Accident/Stroke (the sudden death of brain cells due to lack of

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oxygen when the blood flow to the brain is impaired by blockage or rupture of an artery to the brain), and senile dementia (progressive mental disorder characterized by failing memory, confusion).

The annual MDS (Minimum Data Set-a required assessment) dated 9/17/13 identified the resident with a BIMS (Brief Interview for Mental Status) score of 3/15 (indicating severely impaired cognition), required extensive assistance from two staff with bed mobility, transfers, toilet use, extensive assistance from one staff with personal hygiene, eating, at risk for the development of pressure ulcers, had no pressure ulcers, used a pressure reducing device for the bed, and was on a turning/repositioning program.

Review of the quarterly MDS dated 12/17/13 identified the resident with a BIMS score of 3/15, required extensive assistance from two staff with bed mobility, transfers, toilet use, personal hygiene, required extensive assistance from one staff with eating, at risk for the development of pressure ulcers, had no pressure ulcers, used a pressure reducing device for the bed, and was on a turning/repositioning program.

Review of the Pressure Ulcer CAA (Care Area Assessment) dated 9/24/13 identified the resident at risk for the development of pressure ulcers due to diagnoses of diabetes (when the body can't use glucose, there's not enough insulin made or the body can't respond to the insulin), impaired mobility, pain, bowel and bladder incontinence, and cognitive impairment.

Review of the care plan, dated 12/24/13, identified the resident at risk for impaired skin

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integrity and directed staff to reposition the resident at least every 2 hours and to assist with repositioning as needed. It also guided staff to conduct weekly skin assessments by a licensed nurse, to monitor the resident's skin during dressing, peri-care and bathing for signs of potential skin breakdown (such as redness, discoloration or open areas) and notify the charge nurse of abnormal findings. Other interventions included staff to provide good peri-care with each incontinent episode, apply moisturizing skin lotion to skin after each bath and PRN (as needed), monitor for any unusual brusing or signs/symptoms of infections and to report any bruising noted to the licensed nurse.

On 1/23/14 at 1:20 p.m., observation of the resident revealed he/she sat in a recliner in the lobby, with his/her feet up. The resident sat with his/her eyes open. The resident remained in the lobby, seated in the reclined recliner without a position change through observations at 1:35 p.m., 1:48 p.m., 2:01 p.m., 2:15 p.m., 2:30 p.m., 2:42 p.m., 2:54 p.m., 3:03 p.m., 3:14 p.m., 3:25 p.m., 3:38 p.m., 3:50 p.m., 4:02 p.m., 4:11 p.m., and 4:25 p.m. At 4:34 p.m., after sitting in a reclined recliner for over 3 hours, direct care staff I and M transferred the resident from the recliner into his/her wheelchair, then took the resident to the bathroom. Once in the bathroom, observation of the resident's buttocks revealed the buttocks were a deep, ruddy, red color. The staff failed to provide repositioning services for the resident every 2 hours as planned.

On 1/23/14 at 1:18 p.m., direct care staff F said the resident needed help with all ADLs (Activities of Daily Living), including toileting, repositioning in bed, and eating. Staff F said staff were to

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reposition all residents that could develop a pressure ulcer every 2 hours, whether the residents had one or not, and that included resident #6.

On 1/23/14 at 5:09 p.m., licensed nursing staff N stated the staff were to reposition the residents that needed assistance with moving at least every 2 hours.

On 1/28/14 at 4:50 p.m., Administrative nurse B stated staff were to make sure all residents were repositioned every 2 hours.

Review of the resident's undated policy on Pressure Ulcer Prevention Protocol revealed guidance to staff that resident with risk factors were to have position changes at least every 2 hours during the daytime.

The facility staff failed to provide repositioning assistance for a resident every 2 hours as planned for this cognitively impaired, dependent resident who was risk for pressure ulcers.

- Review of resident #5 ' s diagnoses, located on the admission and discharge summary sheet dated 3/14/13, identified the resident with the diagnoses of DMII (Diabetes Mellitus-when the body can't use glucose, there's not enough insulin made or the body can't respond to the insulin), osteoarthrosis (degenerative changes to one or many joints characterized by swelling and pain), and delusional disorder (an untrue persistent belief or perception held by a person although evidence shows it is untrue).

Review of the significant change in status MDS (Minimum Data Set-a required assessment)

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dated 6/27/13 identified the resident with a BIMS (Brief Interview for Mental Status) score of 5/15 (indicating severely impaired cognition), required extensive assistance from 2 staff with bed mobility, transfers, toilet use, and personal hygiene, was at risk for the development of pressure ulcers, did not have pressure ulcers, used pressure reducing devices for the chair, bed, and was on a turning/repositioning program.

Review of the quarterly MDS dated 12/24/13 identified the resident with short and long-term memory problems, with inattention and disorganized thinking that did not fluctuate, required extensive assistance from 2 staff with bed mobility, transfers, toilet use, personal hygiene, at risk for the development of pressure ulcers, had no pressure ulcers, used a pressure reducing device for the chair/bed, and staff utilized a turning/repositioning program for the resident.

Review of the Pressure Ulcer CAA (Care Area Assessment-a further assessment), dated 6/24/13 revealed the resident had a decrease in mobility, and had lost a significant amount of weight which placed the resident at risk for impaired skin. Other contributing factors included the resident's diagnosis of diabetes with neuropathy (disease or dysfunction of one or more peripheral nerves, typically causing numbness or weakness), bowel and bladder incontinence, impaired cognition and resistance to care.

Review of the care plan, dated 12/31/13, revealed the resident was at risk for impaired skin integrity related to diabetes. It directed staff to apply skin protectant to the resident's buttocks as needed,

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monitor an area on the resident's inner thigh (looks like birthmark) that the resident had said that he/she had for years. If staff noted changes, (such as irregular borders, color or size changes) notify physician. Turn and reposition the resident at least every 2 hours, the facility's licensed nurses were to conduct a weekly skin assessment, monitor skin during care for signs of potential skin breakdown, and apply moisturizing skin lotion to skin after each bath and PRN (as needed).

Review of the nurse's notes revealed on 1/13/14 at 9:43 a.m., staff documented an open spot on the right side of the buttocks. Calmoseptine (type of moisture barrier) applied.

The resident's medical record lacked an assessment of the open area.

Review of the January 2014 TAR (Treatment Administration Record) revealed on 1/13/14 staff received an order to check open area on right buttock and apply Calmoseptine until resolved. Staff signed the order three times a day as completed starting on 1/13/14.

On 1/14/14, the staff sent a fax to the physician asking for an order for calmoseptine to be applied PRN (as needed) as the resident has a 1 centimeter round lesion to coccyx. On 1/14/14, the physician returned the fax with the order of agree with above.

On 1/24/14, the staff sent a fax to the physician with the following information: Patient sore on left buttock is increasing in size [Previous documentation identified open areas on the right buttock and coccyx]. There was a spot starting

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on right buttocks. Staff placed DuoDerm on both, patient has been spending more time in recliner. Pressure cushion was not being used in recliner and wheel chair. Wound to be checked, cleaned and DuoDerm changed every 5 days until resolved. Is this acceptable? On 1/24/14, physician extender responded with agree with above.

On 1/24/14 at 8:38 a.m., direct care staff K entered the resident's room and used a sit to stand mechanical lift to transfer the resident from the wheelchair onto the toilet. Observation revealed a foam cushion in the resident's wheelchair. Staff K removed the resident's wet brief, then assisted the resident to sit on the toilet. The resident voided, staff K obtained a brief and assisted the resident to stand. Observation of the resident ' s buttocks revealed two small, undated DuoDerm dressings (an occlusive dressing) on each ischial tuberosity (when a person is in a seated position, his or her weight typically rests on a section of bone called the ischial tuberosity). Direct care staff J entered the resident's room at that time, carrying a small cup of calmoseptine (moisture barrier cream) and was going to place it on the resident ' s buttocks, but said he/ she saw a new reddened area on the right buttock, so staff J left to get licensed nurse A, the charge nurse. Staff K applied a clean brief and pulled up the resident's pants, but had the resident remaining standing in the mechanical lift, waiting on nurse A.

On 1/24/14 at 8:50 a.m., direct care staff K transferred the resident from the sit to stand lift into the resident s electric recliner. Staff K then reclined the resident back in the chair and left the resident's room.

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On 1/24/14 at 9:55 a.m., licensed nurses A and O entered the resident's room to look at the resident's buttocks but the resident refused. Staff A and O said they would try again right before lunch when staff assisted the resident to the toilet again.

On 1/24/14 at 10:55 a.m., direct care staff L and licensed nurse A used a sit-to-stand mechanical lift, assisted the resident stand, then lowered the resident's dry brief. Observation of the resident ' s buttocks revealed the reddened area on the right buttock from earlier in the morning was no longer present. The DuoDerm on the right buttock had edges that were starting to curl up, and, as a result, observation of the open area was noted. There was no drainage, the wound bed was red and the edges of the wound were reddish/purple in color. Licensed nurse A tried to uncurl the duoderm and lay it back over the wound, then stated it was good enough, and said it would stick better when the resident sat on it some more. The other duoderm on the left buttock remained intact. The staff transferred the resident to the toilet and then into the wheelchair. Observation revealed the resident sat on a foam cushion in the wheelchair.

On 1/24/14 at 8:50 a.m., direct care J, stated that the resident had one area that was really opened, and a reddened area on the other buttock that looked like it could develop into something, which was why staff were using the DuoDerm.

On 1/24/14 at 9:55 a.m., licensed nurse A stated the resident had developed an open area and when he/she measured the area on 1/21/14 and it

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was 8 mm (millimeters) x 5 mm at that time and was looking good. However, licensed nurse P worked yesterday (1/22/14) and must have thought it looked worse, because nurse P put a duoderm on both buttocks, one that had an open area and the other buttock had another area that nurse P thought looked like it might be starting to open. Nurse A stated the resident sat on a foam cushion, but that was a cushion the resident always had.

On 1/24/14 at 9:58 a.m., licensed nurse O stated hospice had ordered a gel cushion for the resident, but it had not arrived yet. Nurse O did not say when hospice ordered the cushion, or how long before it would be in.

On 1/24/14 at 10:55 a.m., licensed nurse A stated that he/she was going to talk to the hospice staff again. Nurse A said the nursing staff had just started the Calmoseptine ointment on 1/21/14 and it had only been used for a day when licensed nurse P started to use the DuoDerm. Nurse A said that was not long enough to see if the Calmoseptine would work.

On 1/24/14 at 4:50 p.m., Administrative nurse B, stated staff should have done an assessment on the resident ' s open area when it first developed, then did one weekly.

Review of the facility's undated Pressure Ulcer Prevention protocol, directed staff to conduct weekly skin assessments for pressure ulcers using an EZ graph that included staging, size, depth, drainage, tunneling, odor, degree of healing and assessing the resident's pain associated with pressure areas.

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Staff failed to complete comprehensive assessments of a resident's newly-developed pressure ulcer.

- Review of the closed medical record for resident #2 revealed a physician's review of orders dated 10/15/13 that identified the resident had the diagnoses of Alzheimer's (progressive mental deterioration characterized by confusion and memory failure), CAD (Coronary Artery Disease-abnormal condition that may affect the flow of oxygen to the heart), DM (diabetes mellitus-when the body can't use glucose, there's not enough insulin made or the body can't respond to the insulin), and chronic renal failure (inability of the kidneys to excrete wastes, concentrate urine and conserve electrolytes).

Review of the annual MDS (Minimum Data Set-a required assessment) dated 4/9/13 identified the resident with short and long-term memory problems, modified independent in making decisions regarding tasks of daily life, and had daily inattention and disorganized thinking. The assessment also identified the resident required extensive assistance from one staff with bed mobility and transfers, was at risk for the development of pressure ulcers, did not have any pressure ulcers, used a pressure relieving device while in the chair and bed, and was on a turning/repositioning program.

Review of the quarterly MDS dated 10/1/13 identified the resident with a BIMS (Brief Interview for Mental Status) score of 3/15 (indicating severely impaired cognition), required extensive assistance from two staff with bed mobility, transfers, was at risk for the development of pressure ulcers, had no pressure ulcers, used a

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pressure relieving device for the bed/chair, was on a turning/repositioning program, and staff applied nonsurgical dressings other than to feet.

Review of the Pressure Ulcer CAA (Care Area Assessment-a further assessment), dated 4/16/13, identified that resident had no significant change from the prior comprehensive assessment. It identified the resident at moderate risk for the development of pressure ulcers. It also identified the resident had a diagnosis of diabetes, was chair bound, needed assistance with repositioning, incontinent of both bowel and bladder and needed assistance for adequate nutrition.

The care plan for skin integrity, dated 10/8/13 directed staff to assist with repositioning at least every 2 hours, a licensed nurse was to conduct a weekly skin assessment, monitor skin during dressing, peri-care and bathing for signs of potential skin breakdown (such as redness, discoloration or open areas) and notify the charge nurse of abnormal findings - particularly to feet and hands. Provide good peri-care with each incontinent episode, apply moisturizing lotion to skin after each bath and PRN (as needed).

Review of the nurse's notes revealed the following:

On 11/28/13 at 9:30 a.m., RN (Registered Nurse) noted small open area on lt (left) buttocks as received via nurse shift report, barrier cream applied per orders. Will continue to monitor.

On 11/29/13 at 1:00 p.m., family and hospice staff both looked at small areas of skin breakdown.

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F 314	Continued From page 42 Review of the November 2013 TAR (Treatment Administration Record) revealed staff wrote an order for Calmoseptine (a type of barrier cream) on 11/29/13 and started the order between 2-10 p.m. that day. Review of the medical record revealed it lacked a comprehensive assessment of the resident's open areas. Review of the medical record revealed the resident expired in the evening of 11/30/13. The facilty failed to conduct a comprehensive assessment of a resident's newly-developed pressure ulcer.	F 314		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: The facility census totaled 98 residents with 8 included in the sample. Based on observation, interview and record review, the facility failed to ensure staff safely used the mechanical lift, used the appropriate type of mechanical lift and failed to use gait belts when transferring 3 residents. The facility also failed to provide sufficient	F 323		

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supervision for 1 resident with multiple falls. (#2, #5, #6, and #8)

Findings included:

- Review of an admission and discharge summary sheet, dated 3/14/13, identified resident #5 with the diagnoses of osteoarthrosis (condition of chronic arthritis without inflammation), idiopathic peripheral neuropathy (a disorder that affects the peripheral nerves and has no identifiable primary cause), macular degeneration (eye disease caused by degeneration of the cells that results in blurred vision; can cause blindness), and delusional disorder (an untrue persistent belief or perception held by a person although evidence shows it is untrue).

Review of the significant change in status MDS (Minimum Data Set-a required assessment) dated 6/27/13 identified the resident with a BIMS (Brief Interview for Mental Status) score of 5/15 (indicating severely impaired cognition), required extensive assistance from 2 staff with bed mobility, transfers, toilet use, and personal hygiene.

Review of the quarterly MDS dated 12/24/13 identified the resident with short and long-term memory problems, with inattention and disorganized thinking that did not fluctuate, required extensive assistance from 2 staff with bed mobility, transfers, toilet use, and personal hygiene.

Review of the ADL (Activities of Daily Living) CAA (Care Area Assessment) dated 7/3/13 identified the resident was chair bound and primarily a 2 staff assist for all other ADLs except eating. Staff

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report the resident demonstrated signs of pain with movement and mechanical lift use.

Review of the care plan, dated 12/31/13, identified the resident required 2 staff assist with bed mobility, toileting, dressing and a sit to stand mechanical lift for transfers.

On 1/24/14 at 8:38 a.m., direct care staff K entered the resident's room with a sit to stand lift and used it to transfer assist the resident to stand up from the wheelchair and transfer onto the toilet. Staff K kept repeating over and over to the resident what staff K was helping the resident to do, but the resident would grasp the handles on the lift for a short time, then let go. Finally, after multiple attempts, staff K got the resident to grasp the handles and hang on long enough while staff K raised the lift. Staff K then transferred the resident onto toilet. Once completed on the toilet, staff K assisted the resident to grab onto the handles on the lift, raised the resident, and transferred the resident to a recliner.

On 1/24/14 at 10:55 a.m., direct care staff L and licensed nurse A, entered the room with a sit-to-stand lift. The staff took several minutes to try to help the resident grasp the appropriate handles on the sit to stand lift. Staff L stated "I usually start to raise the lift, that helps [him/her] to realize that [he/she] is going to be standing up and [he/she] will grab the handles more easily then." So staff L started to raise the lift without the resident hanging onto the handles on the lift and the resident, realizing that he/she was being lifted into a standing position, allowed staff L and nurse A to guide his/her hands to the handles and the resident held on. The staff then helped to transfer the resident onto the toilet, then up again

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and to the a wheelchair.

On 1/24/14 at 1:14 p.m., observation revealed direct care staff L and Q pushed the resident to his/her room and used a sit to stand mechanical lift to transfer the resident. The staff used multiple attempts to have the resident grasp the handles while in a seated position and the resident did not hang onto the handles for very long, so the staff started to raise the resident into a standing position and the resident, who then realized that he/she was beginning to stand, allowed the staff to guide his/her hands to the handles and he/she hung on for the remainder of the transfer. The staff transferred the resident from the wheelchair to the toilet, then to the recliner.

On 1/24/14 at 8:43 a.m., direct care staff K stated that the resident usually did "pretty good" with the sit to stand lift-it was just a chore to get the resident to understand what was happening. Once the resident understood, then the resident helped with standing. There were times, though, that the resident seemed to have pain and did not want to stand.

On 1/28/14 at 11:30 a.m., therapy staff R stated that the residents who come in needing skilled services were assessed initially and their transfer status determined regarding what would be the safest method. Those that had declines in their abilities, then the therapy department was notified by the nursing staff of the decline, and the therapy staff would get an order from the physician to complete an evaluation of the resident's transfer abilities. When asked specifically about resident #5, staff R did not remember staff identifying the resident with

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declines in transfer abilities.

On 1/28/14 at 4:50 p.m., Administrative nurse B stated that it was true that the staff needed to tell the therapy staff to review the residents when nursing felt like the transfers were no longer safe for the residents. Nurse B shook his/her head "no" when told some staff were having the resident stand without assisting the staff to get the resident to understand what was happening.

Review of the facility's undated policy on Safe Lifting and Movement of Residents revealed that nursing staff, in conjunction with the rehabilitation/therapy staff, shall assess individual resident's needs for transfer assistance on an ongoing basis. All transfers with a full mechanical lift must be performed with no less than 2 staff. Staff will document resident transferring and lifting needs in the care plan. Such assessment shall include: the resident's mobility (degree of dependency), resident's size, weight-bearing ability, cognitive status, and any behaviors. The policy also identified that staff not following the care plan instructions regarding lift requirements would result in disciplinary action, up to and including termination of the employee.

The facility staff failed to use a mechanical lift in the safest manner to prevent accidents for this confused resident.

- Review of the physician review of orders signed on 10/15/13 identified resident #2 had diagnoses of Alzheimer 's disease (progressive mental disorder characterized by failing memory, confusion), CAD (Coronary Artery Disease--abnormal condition that may affect the flow of oxygen to the heart), DM II (Diabetes Mellitus,

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type II--when the body can't use glucose, there's not enough insulin made or the body can't respond to the insulin), and chronic renal failure (inability of the kidneys to excrete wastes, concentrate urine and conserve electrolytes).

Review of the annual MDS (Minimum Data Set-a required assessment) dated 4/9/13 identified the resident with short and long-term memory problems, modified independence in making decisions regarding tasks of daily life, had daily inattention and disorganized thinking. The assessment also identified the resident required extensive assistance from one staff with bed mobility and transfers.

Review of the quarterly MDS dated 10/1/13 identified the resident with a BIMS (Brief Interview for Mental Status) score of 3/15 (indicating severely impaired cognition), required extensive assistance from two staff with bed mobility and transfers.

Review of the care plan, dated 10/8/13, identified the resident required bed mobility with 1-2 staff assist, and used a mechanical lift with 1-2 staff assist for transfers. On 11/28/13 at 1:30 p.m., staff changed that to "use of full mechanical lift as resident is not holding onto sit to stand lift with 2 person assist."

Review of the nurse's notes, revealed on 11/26/13 at 9:30 a.m., staff documented the resident had an "overall general decline" noted by several staff. The documentation revealed the resident tended to " look up " , frequently had a blank stare and slept a lot during the day-even throughout meals.

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On 11/27/13 at 9:10 a.m., staff documented they called and notified the family and faxed the physician to let them know of the resident's general decline, including the staring, frequent sleeping, and poor appetite.

On 11/28/13 at 1:15 p.m. the documentation revealed the family expressed concerns that included what the family thought was unsafe conditions the facility used to transfer the resident. The staff documented they told the family they would no longer use the sit to stand lift with the resident, but use a full body lift.

On 11/28/13 at 1:30 p.m., staff documented they updated the resident's care plan to include the use of a full mechanical lift with 2 person assist for transfers as resident was unable to hold onto sit-to-stand lift.

On 1/28/14 at 11:30 a.m., therapy staff R stated that the residents who come in needing skilled services were assessed initially and their transfer status determined regarding what would be the safest method. Those that had declines in their abilities, then the therapy department was notified by the nursing staff of the decline, and the therapy staff would get an order from the physician to complete an evaluation of the resident's transfer abilities. When asked specifically about resident #2, staff R did not remember staff identifying the resident with declines in transfer abilities.

On 1/28/14 at 4:50 p.m., Administrative nurse B stated the resident had a decline in the weeks before his/her death. Nurse B stated staff should have had the therapy department re-evaluate the safety of the transfer once the resident stopped

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holding onto the sit to stand lift.

Review of the facility's undated policy on Safe Lifting and Movement of Residents revealed that nursing staff, in conjunction with the rehabilitation/therapy staff, shall assess individual resident's needs for transfer assistance on an ongoing basis. All transfers with a full mechanical lift must be performed with no less than 2 staff. Staff will document resident transferring and lifting needs in the care plan. Such assessment shall include: the resident's mobility (degree of dependency), resident's size, weight-bearing ability, cognitive status, and any behaviors. The policy also identified that staff not following the care plan instructions regarding lift requirements would result in disciplinary action, up to and including termination of the employee.

The facility staff failed to ensure safe transfers for this resident with declining health.

- Review of the physician's review of orders, dated 12/17/13, identified resident #6 with the diagnoses of osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain) and senile dementia (progressive mental disorder characterized by failing memory, confusion).

Review of the annual MDS (Minimum Data Set-a required assessment) dated 9/17/13 identified the resident with a BIMS (Brief Interview for Mental Status) score of 3/15 (indicating severely impaired cognition), required extensive assistance from two staff with bed mobility, transfers, and toilet use.

Review of the quarterly MDS dated 12/17/13

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identified the resident with a BIMS score of 3/15, required extensive assistance from two staff with bed mobility, transfers, toilet use, and personal hygiene.

Review of the care plan, dated 12/24/13, identified the resident required extensive assistance from 1-2 staff with transfers.

On 1/23/14, observation revealed the resident sat in a recliner in the lobby area. Direct care staff I and M approached the resident with a gait belt. Staff I placed the gait belt around the resident's abdomen, and then staff I and M assisted the resident to stand up out of the recliner by lifting and pulling the resident under the arms. Staff I and M did not use the gait belt during the transfer.

On 1/28/14 at 11:30 a.m., therapy staff R identified safe transfers of residents were done with the use of a gait belt. Staff R stated the gait belts were used so staff did not injure residents by pulling and lifting the residents by the arms.

On 1/28/14 at 4:50 p.m., Administrative nurse B stated that staff were not to transfer residents by lifting the residents under the arms, the staff were to use gait belts.

Review of the facility's undated Safe Lifting and Movement of Residents policy revealed mechanical lifting devices shall be used for heavy lifting, including lifting and moving residents. Except during an emergency or unavoidable circumstance, manual lifting is not permitted.

The facility failed to ensure the transfer of a resident remained as safe as possible through a failure to use a gait belt.

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- Review of the admission and discharge summary sheet, dated 12/20/13, identified resident #8 had the diagnoses of depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness), postural hypotension (low blood pressure occurring in some people when they stand up), osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain), and renal insufficiency (inability of the kidneys to sufficiently excrete wastes, concentrate urine and conserve electrolytes).

Review of the significant change in status MDS (Minimum Data Set-a required assessment) dated 12/29/13 identified resident #8 with short and long-term memory problems, with moderately impaired cognition, had consistent inattention, disorganized thinking, inconsistent altered level of consciousness, required extensive assistance from two staff with bed mobility, transfers, walking in the room, toilet use, personal hygiene, and had one non-injury fall since the last assessment.

Review of the Fall CAA (Care Area Assessment, completed with the MDS on 12/29/13, identified the resident at risk for falls, had a recent history of falls, and also fell since admission. Particularly early in the assessment period, the resident was restless, tried to climb out of bed or the wheelchair, wandered while in the wheelchair and was resistive to care. It also identified the resident required 1-2 assist of staff for ADLs (Activities of Daily Living), had confusion, difficulty communicating, occasional incontinence, orthostatic hypotension and received psychotropic medication.

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Review of the care plan, dated 1/7/14, identified the resident required 2 staff assist with bed mobility, transfers and ambulation. It also identified the resident used a walker and his/her gait was slow and directed staff to not to rush the resident. The fall care plan directed staff to cue the resident to change positions slowly to avoid increased dizziness. Do not encourage the resident to ambulate after standing until he/she felt the dizziness had resolved, and to use standard fall precautions, which included the following: keep call light within reach, instruct and encourage the use of call system. Respond promptly to call light. Keep as many items as possible within the resident's reach so that reaching is not necessary. Bed in low position, casters locked. Wheelchair locked when not in motion. Keep room clean, pathways, clear. Ensure clear access from bed to bathroom. Monitor for safety hazards(such as water on floor, papers or trash on floor). Shoes, footwear on when the resident is up. Non-skid socks on when in bed. Monitor for condition/fit of shoes. Have repaired/replaced as needed. The care plan failed to address the need for increased supervision.

Review of the fall investigations revealed the following:

On 10/23/13 at 6:00 p.m., staff observed the resident sitting on his/her buttocks in doorway to his/her room, the wheelchair was in the hallway. Staff documented the an intervention that staff educated the resident to not stand up from wheelchair before locking it. Staff were also educated to monitor the resident as he/she sat in the wheelchair.

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On 11/17/13 at 6:45 p.m., staff documented another resident observed resident #8 stand up, walk a few steps independently, then leaned over and fell onto his/her bottom. The intervention developed by staff included closer observation by staff as the resident had been "up and down all shift."

On 11/19/13 at an untimed entry, staff documented hearing a personal body alarm sounding in the lobby/common area. The charge nurse found the resident on the floor lying on his/her right side, the w/c (wheelchair) next to him/her, wheels not locked. Review of the new intervention documented by staff included the resident should be monitored closely, kept in sight by staff.

On 12/24/13 at 6:15 p.m., staff responded to alarm, but unable to stop fall as resident fell out of wheelchair, attempting to stand. The resident landed on his/her right side. Documentation of new intervention by staff the resident required constant one on one.

On 1/18/14 at 12:20 p.m., Resident was using tab alarm and wheelchair, seated in commons area. The tab alarm sounded nurse and other staff in dining room. Resident observed slipping out of w/c, unable to get to resident in order to prevent fall. Slowly slipped from w/c to floor. Staff assisted resident back into w/c after physical assessment. Staff documented the new intervention included place in dining room where staff can quickly reach resident when alarm sounds.

On 1/24/14 at 7:46 a.m., observation revealed direct care staff S sat down next to the resident

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 54 and started to assist the resident to eat. The resident did not open her eyes. On 1/24/14 at 8:15 a.m., observation revealed direct care staff K pushed the resident out of the dining room to a table in the lobby. Staff K left the resident at the table and returned to the dining room and assisted another resident to finish eating. Observation revealed the back of the resident ' s wheelchair had a personal body alarm attached to it and there were no nursing staff in the lobby to observe the resident. On 1/24/14, at 9:15 a.m., direct care staff L stated the resident at times could get restless, but now that the resident was on hospice, the resident had more days where all he/she did was sleep. Staff L could not remember how long the resident had been on hospice. On 1/28/14 at 4:50 p.m., Administrative nurse B agreed the staff did not do the closer supervision that was recommended after multiple falls. Review of the undated Fall Management Program policy revealed it directed staff to observe the residents every 60 minutes, at a minimum, and apply a personal alarm for elders who attempt to get out of bed or chair unassisted. The staff were also to monitor and document the resident's response to interventions intended to reduce falling or the consequences of falling. The facility failed to provide sufficient supervision for a resident with multiple falls.	F 323		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE	F 325		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175385	A. BUILDING _____ B. WING _____	C 01/31/2014

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F 325	Continued From page 55	F 325		

Based on a resident's comprehensive assessment, the facility must ensure that a resident -
(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and
(2) Receives a therapeutic diet when there is a nutritional problem.

This REQUIREMENT is not met as evidenced by:
The facility census totaled 98 residents with 8 included in the sample. The sample included the review of 3 residents with the potential for weight loss. Based on interview and a closed record review, the facility failed to consistently provide the planned nutritional supplements to 1 of 3 sampled residents. (#2).

Findings included:

- Review of the physician's review of orders signed on 10/15/13 revealed resident #2 had the diagnoses of Alzheimer's (progressive mental disorder characterized by failing memory, confusion), DM (Diabetes Mellitus, and GERD (Gastro-Esophageal Reflux Disease-- backflow of stomach contents to the esophagus).

Review of the annual MDS (Minimum Data Set-a required assessment) dated 4/9/13 identified the resident with short and long-term memory problems, modified independence in making decisions regarding tasks of daily life, had daily inattention and disorganized thinking. The

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F 325	Continued From page 56	F 325		

assessment also identified the resident as independent with eating, had no chewing/swallowing problems, a steady weight of 150 pounds and received a mechanically altered, therapeutic diet.

Review of the quarterly MDS dated 10/1/13 identified the resident with a BIMS (Brief Interview for Mental Status) score of 3/15 (indicating severely impaired cognition), required extensive assistance from one person with eating, a steady weight of 151 pounds, and received a mechanically altered, therapeutic diet.

Review of the Nutritional Status CAA (Care Area Assessment-a further assessment) dated 4/16/13 identified the resident had no significant change from the prior comprehensive assessment. It identified the resident had physician's orders for a pureed, low concentrated sweet (LCS), honey thickened liquid diet and received routine insulin injections. The assessment identified the resident as independent with eating at times but staff usually fed the resident.

Review of the resident's nutrition care plan, dated 10/8/13, identified the resident required a LCS, pureed diet and thickened liquids. It directed the staff to allow the resident to make choices within limits of diet, learn to know (and share with other staff) what the resident liked and did not like due to his/her communication deficit, and assist with feeding. Offer small amounts of food at a time. Allow the resident to hold his/her cup when able. Assess response to diet and request an order for any modification as needed. Nourishing snacks as allowed within diet limits. Laboratory tests as ordered by the physician. Notify physician of abnormal results. Health shakes PRN (as

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F 325	Continued From page 57	F 325		

needed) if the resident eats 50% or less.

Review of the electronic record revealed the staff documented the residents weights as follows:

08/05/13 156.2 pounds
09/02/13 151.2
10/06/13 153.4
11/02/13 153.8
11/30/13 150.2

The documentation showed the resident lost 2.3% of his/her weight in November 2013.

Review of the facility's food intake record for the resident for November 2013 revealed of the 90 meals offered to the resident for the month, the resident ate 50% or less at 66 of them. Of those 66 meals, the documentation revealed staff did not offer a health shake at 47 of those meals, or over 71% of the time.

Review of the November 2013 MAR (Medication Administration Record) revealed it lacked an order for staff to offer a health shake if the resident ate 50% of meals or less.

Review of the nurse's notes revealed the resident died in the evening on 11/30/13.

On 1/28/14 at 4:50 p.m., Administrative nurse B stated the staff were supposed to document the amount of health shake consumed on the MAR (Medication Administration Record). When told that staff had not done that, nor had they documented they offered a supplement when the resident ate 50% or less in the electronic intake record, nurse B stated he/she would have to look into that to see why they documented things that

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F 325	Continued From page 58 way. Review of the facility's undated Nourishment/Supplement policy revealed that the supplements were ordered by the physician and recorded on the MAR by the direct care staff trained in administering medications. In addition to initialing that the supplement was administered, the total amount consumed in cc's (cubic centimeters) was also to be placed on the MAR. The direct care staff were to notify the charge nurse when the resident did not consume the entire amount ordered. The facility staff failed to offer a health shake if the resident ate 50% or less as planned for a resident at risk for weight loss.	F 325		